EXHIBIT 103

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MASSACHUSETTS

IN RE: PHARMACEUTICAL INDUSTRY	)	MDL NO. 1456
AVERAGE WHOLESALE PRICE	)	
LITIGATION	)	CIVIL ACTION:
	)	01-CV-12257-PBS
	)	Judge Patti B. Saris
	)	Magistrate Judge
	)	Marianne B. Bowler

THIS DOCUMENT RELATES TO

U.S. ex rel. Ven-A-Care of the

Florida Keys,Inc., v.

Abbott Laboratories, Inc., et al.

No. 06-CV-11337-PBS

(Caption continues on next page.)

VIDEOTAPED DEPOSITION OF

CODY WIBERG

Taken March 14, 2008

Commencing at 9:13 a.m.

COMMONWEALTH OF KENTUCKY
FRANKLIN CIRCUIT COURT - DIV 1
CIVIL ACTION NO. 04-CI-1487

COMMONWEALTH OF KENTUCKY PLAINTIFF
ex rel. JACK CONWAY, ATTORNEY GENERAL
v.
ALPHARMA USPD, INC., et al.

VIDEOTAPED DEPOSITION OF
CODY WIBERG
Taken March 14, 2008
Commencing at 9:13 a.m.

REPORTED BY: SUZANNE HAGEN, RPR, CRR, CBC

Videotaped Deposition of Cody Wiberg, taken on March 14, 2008, commencing at 9:15 a.m., at the law firm of Meagher & Geer, 33 South Sixth Street, #4400, Minneapolis, Minnesota, 55402, before Suzanne Hagen, Registered Professional Reporter, Certified Realtime Reporter, Certified Broadcast Captioner, and Notary Public of and for the State of Minnesota.

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Also Present:
Kelly Leber, Videographer

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(Deposition Exhibit Abbott 650 marked for identification.)

VIDEOGRAPHER: Good morning. We are going on the record. This is the videotaped deposition of Cody Wiberg, taken on March 14, 2008. Time now is approximately 9:12 a.m. The deposition is being taken in the matter of Pharmaceutical Industry, Average Wholesale Price Litigation. Also, Commonwealth Kentucky, Jack Conway, Attorney General, versus ALPHARMA USPD, Inc., et al, in United States District Court for the District of Massachusetts, case number 01-CV-12257-PBS. Also taken in the matter of State of Texas versus Abbott, District Court of Travis County, Texas.

The deposition is taking place in Minneapolis, Minnesota. My name is Kelley Leber; I'm the videographer representing Henderson Legal Services. Will counsel please identify themselves for the record?

MR. COOK: I'm Christopher Cook from Jones Day. We represent Abbott Laboratories.

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A. Oh, yes, yes, indeed.
Q. We'll get to that in detail later, but could you describe that work at a high level of generality?
A. Well, basically, again, under federal law, states are allowed to set reimbursement rates for pharmaceuticals. And so since we managed the fee for service pharmacy program, we obviously had a lot to say about what those rates should be.
Q. And you -- did you work with the legislature and the legislature's passing of laws that related to dispensing fees and reimbursement formula?
A. That's correct. Unlike some other states, where Medicaid reimbursement rates can be set by the agency, by rule, in Minnesota, unless things have changed, and at least in the pharmacy area, and I think in most areas, the legislature establishes the rates.
MR. COOK: Mr. Wiberg, let me hand you what we have marked in previous depositions as Exhibit Abbott 19.
THE WITNESS: It's a copy of the

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complaint in this case.
MR. BLACK: I just want to see which case.
MR. COOK: It is the complaint that was originally filed or the complaint and intervention filed by the Department of Justice. And it's Abbott.
MR. BLACK: Intervention?
MR. COOK: It's the complaint and intervention. And for the record -- it was filed in March of 2006.
BY MR. COOK:
Q. Just as an initial matter, Mr. Wiberg, have you ever seen this document before, to your knowledge?
A. I'm not sure. Unless you've -- folks sent it to me, then I don't believe that I have, no.
Q. Okay. Well, actually what I'd like to turn your attention to is the very last two pages of the document that are labeled Exhibit 1. And it's a list of drugs.
A. Uh-huh.

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Q. And could you take a look at those drugs and tell me if you -- if you recognize those drugs?
A. The top one appears -- the top two appear to be cut off. But otherwise, yes.
Q. And does this appear to be a -- to describe them at a -- at a higher level of generality? Sodium saline solution, dextrose solution, vancomycin, and water.
A. Uh-huh.
Q. What kinds of drugs are-- are those?
A. At a high level, I think what you want to know is they're injectable drugs. They're drugs that are commonly used in -- in IV therapy.
Q. These wouldn't be the types of pills, for example, that you were dispensing when you were -- a community -- community pharmacist, right?
A. That's correct.
Q. And as we go along, and happy to have you -- you keep a copy of that. When I refer to the subject drugs in the federal case, I'm referring to the drugs that are here on Exhibit 1. These are the ones that are the subject of the government's

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lawsuit against -- against Abbott.
A. Uh-huh.
Q. Do you know what the allegations are that have been made by the Department of Justice in this case against Abbott?
A. In this particular case, no. Because I have not read this document.
Q. Are you familiar generally with the AWP litigation that's been going on for so many years in the country?
A. Yes, I have.
MR. FAUCI: Objection, form.
BY MR. COOK:
Q. What is your understanding of what that AWP litigation relates to?
MR. FAUCI: Objection to form.
A. I think my understanding is that the basic allegation is that pharmaceutical manufacturers either falsely reported information or withheld information about the true cost of pharmaceuticals that they, in fact, inflated average wholesale prices in an effort to win market share for their

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any drug that was already on the federal upper limit list. And there -- and CMS took a long time after generics became available to put those generics on the federal upper limit list. So that's one thing we couldn't do. We also had to have the brand name, plus at least two generics.

After 2002, when I got that language reversed, we went -- we again had the authority to establish a MAC on anything that had at least one generic. And so that's what we did. As drugs went off patent and generics were introduced, as soon as those drugs were out in the market, we would MAC the products.

Q. We'll come to it in more detail in a little bit, but you refer to the legislature and influence from affected constituencies affecting eventually legislation, right?

A. Yes.

Q. Was it a political policy decision in Minnesota how much it was that Minnesota Medicaid was paying for prescription drugs?

A. A political -- what's a political policy

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decision?

Q. You're right.

MR. BLACK: Good question.

BY MR. COOK:

Q. I can ask that better. The amount that Minnesota Medicaid was paying for drugs at the end of the day was the result of the political process. Is that a fair summary?

MR. FAUCI: Objection.

A. Well, it was set by the legislature. The legislature consists of politicians. That's the way it worked in Minnesota. It was not a regulatory or bureaucratic decision. The rates for all Medicaid payments were set by the legislature.

Q. Is this a good time for a short break --

A. Yeah.

Q. -- since we're coming to the end of another tape?

A. Sure.

MR. COOK: We can go off the record.

VIDEOGRAPHER: We are going off the video record at 11:19 a.m.

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(A brief recess was held.)

VIDEOGRAPHER: We are now back on the record. This is the continuing videotaped deposition of Cody Wiberg, taken on March 14th, 2008. Time now is approximately 11:26 a.m.

BY MR. COOK:

Q. Mr. Wiberg, if I could turn your attention back to Exhibit 19, it's the -- the complaint with the list of subject drugs on it.

A. Okay.

Q. In what circumstances -- we started to touch on this a minute ago with the managed care versus the fee for service. But in what circumstances would the fee for service portion of Minnesota Medicaid pay for these products?

A. Well, directly -- there would be two ways. It would be direct and indirect. To the extent that the Medicaid program paid for anyone who was hospitalized as an inpatient, that would be one way, which I had nothing to do with, because that's all essentially a capitated arrangement based on what are called DRGs.

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In terms of the outpatient setting, we would pay for these -- probably primarily to home I.V. infusion pharmacies, or at least they would be the pharmacies that would be most likely to dispense these sort of products.

As I believe I mentioned earlier on, there are some pharmacies that are a hybrid. I mean, there are some pharmacies, particularly in outstate Minnesota, where the -- the larger home I.V. infusion pharmacies may not have a presence, or where the pharmacist thought that they could compete locally because of the local reputation, or whatever reason. There's a combination. They run a community pharmacy, and they also have facilities to do home I.V. infusion. But my -- my guess would be, and it is a guess, but -- because I didn't look at these specific products to see who exactly -- which pharmacies exactly we paid for, but it would make more sense that we paid for more of these for home I.V. infusion pharmacies.

Q. Would there also be circumstances in which those particular products would be paid in a

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managers were paying. At the time, some of the reimbursement -- the reimbursement rate -- there is a report that was put out by -- I think it's called the Pharmacy Benefit Management Institute. And if I remember the methodology they used, they surveyed 500 large employers around the country, and asked, what does the Pharmacy Benefit Manager you contract with, what's the reimbursement rate for pharmacies? They were reporting -- I think it was something in the range of AWP minus 13.5 percent, plus a little over $2 in the dispensing fee. So part of it was looking at what the private sector was paying, because we knew the argument. If we tried to undercut the private sector from the pharmacy groups, would be -- you're -- you know, this is a publicly-funded program. It's more difficult to manage Medicaid patients. You're paying us less than private payers will pay. That's one thing.

But then in Minnesota, Minnesota is unique in one aspect. Minnesota has the lowest level of uninsured people in the country. The reason we do that is because we have a program called

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MinnesotaCare. MinnesotaCare is funded by a 2 percent tax, or at least at the time it was 2 percent. It might be down to 1.5 percent now. But at the time, it was a 2 percent tax on all providers. Health care providers. In the case of hospitals, physicians, dentists, those sort of health care providers, it's just a 2 percent tax that they pay. I'm not sure what the -- in their regards, I'm not sure what it is. I don't know if it's off of gross revenues or whatever, but it's -- it's applied directly to them. In the case of pharmaceuticals, it's not applied to pharmacies, it's applied to drug wholesalers. And the drug wholesalers are allowed to pass that on to pharmacies. So, in effect -- and, for private payers, pharmacies can pass that on to cash-paying customers, or they can pass it on to other third-party payers. They can't pass it on to Medicaid. So in effect, their argument was that that in itself was a 2 percent hit. They're wrong. It's not a 2 percent hit off of a published AWP. It's 2 percent off what their actual acquisition

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cost is. But there is some percentage that they're -- they have to pay into the state in the form of this tax that they're not -- we're not otherwise considering. So that's -- so there is a whole bunch of considerations that went into coming to that AWP minus 14.

Q. And, of course, one consideration would be whatever the formula, setting a number that is high enough to ensure access to care for Medicaid beneficiaries, right?

A. Correct.

Q. Because as I understand it, correct me if I am wrong, Minnesota Medicaid is a voluntary program, right? That is, for the pharmacies.

A. Yes, yes.

Q. And so --

A. Provider, yeah.

Q. And so if you don't pay enough money, pharmacies won't participate, Medicaid beneficiaries won't be able to get their drugs, right?

A. Yes, that would be a possibility.

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Q. And, as I understand it, that aspect of the policy-making would be taken care of by pharmacies essentially lobbying their representatives in the legislature.

A. In terms of trying to -- to make sure that we didn't cut reimbursement.

Q. Well, the legislature didn't cut reimbursement too much.

A. Excuse me. Right. That the legislature didn't adopt our proposals to cut reimbursement. Certainly, there were -- there would be the Minnesota Pharmacists' Association was lobbying against what we were doing. I -- I believe the National Association of Chain Drugstores. I don't know this, but I presume that there were individual pharmacists around the state buttonholing their individual legislators, probably.

Q. Did you ever actually look at compendia that published AWPs, whether it's First DataBank, Red Book or some others?

A. We had -- yeah, but not for -- not for purposes of doing pricing. We got -- we received

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considerations at the time.
So if you wanted to make it -- and you would have three choices, basically. You could either make it -- try to make it as close as you could to revenue-neutral. You could try to recoup savings. And therefore, you -- you're going to set the dispensing fee maybe not as high as you would if you were going make it revenue-neutral. Or you could try to actually pay providers more money then, and you would set it a little bit higher. But I basically -- when this came out, and at that conference I mentioned, where -- where Mr. Lup -- Mr. Lupinetti and I both were presenters at a conference. We were talking about different issues, and I was not talking about this particular issue, per se. But he was talking about this issue. And I did basically bring up that, you know, you really have to understand how the pharmacy reimbursement system works. You can't -- you have to understand that there's two sides of the equation, that the dispensing fees are kept artificially low. That if you just reduce the

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ingredient reimbursement to actual acquisition cost, and don't do anything with the dispensing fee, there's at least the possibility that you're going to have access problems for patients, because pharmacies at that point might drop out of the system.
Now, there's an argument that it really wouldn't make much difference, because the very large national pharmacy chains don't necessarily make their money on the prescriptions. They make the money on what you buy in the front end of the store. And if they use pharmacy sales or prescription sales as a loss leader, they'll still sign up for Medicaid.
Q. There will be a retail pharmacy, correct?
A. Yeah.
Q. Not a closed pharmacy like an infusion pharmacy.
A. No, no. So there's that argument. But anyway, the argument I made is that you can't -- you can't look at one side of the equation. You have to look at both sides of the equation. You

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have to understand that we know, and this is a serious aspect of ain't what paid -- "ain't what's paid." We know AWP, "ain't what's paid." But if we move towards more transparency and we get closer to reimbursing on the ingredient side at what providers actually pay, then we have to look at the dispensing fee side in the case of pharmacies, because we've always kept that below what we think the true cost of dispensing is to make up for the fact that there is some money being made on the ingredient side. So to the extent, again, that you start paying people a dispensing fee or a total reimbursement that does not even get back the cost of the drugs, plus the cost of labor and the computer systems and the lights and all that, you could have providers stop -- you know, start dropping out of Medicaid. And then this creates an access issue for very poor people. So -- yeah.
MR. BLACK: Objection, form. Nonresponsive.
BY MR. COOK:
Q. And so would it be your understanding that if

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we were -- if one were to go to this ideal world in which AWP actually represented acquisition costs, the Medicaid programs would no longer use an AWP minus a percentage.
A. To the extent that -- that whatever was used, revamped AWP or an ASP or an AMP, whatever you use as a basis of a cost reimbursement, or -- or excuse me, ingredient reimbursement to the extent that that closely reflected the average actual price the providers paid, then you would -- right. You would no longer be taking percentages off.
Q. And, in fact, are you familiar with the manner in which the federal legislation has changed the calculation of federal upper limits to be two-and-a-half times the Average Manufacturer's Price?
A. If that's a recent change within the last two-and-a-half years, I wouldn't know.
Q. And we've already talked about Medicare paying ASP plus some percentage, correct?
A. 6 percent, I believe it is, yep.
Q. Once you learned what the actual amounts were